Synopsis for PhD in Department of Social Work,
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Title:

A Study of Health Services Delivery through Adolescent Friendly Health Clinics (Anwesha Clinics) in Birbhum, West Bengal

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Introduction

Adolescence is a very significant stage in life which is full of opportunities as well as risks. The adolescents have their own specific needs. This time is a clearly defined psychological, physical and social stage in everybody's life. Exploration and experimentation tendency of adolescents often lead them into risk behaviours and unwanted pregnancies, HIV/AIDS and other sexually transmitted diseases, substance abuse and other injuries from violence.

Evidence provided by SRS 1999, Census 2001, NFHS-II and DLHS-RCH, 2004 particularly on early marriage, teen pregnancy, anaemia and unmet need for contraception led the Government of India to recognize the importance of adolescent health. In India, more than 50% of the illiterate girls get married before they reach the legal age of 18 years (ibid). Nearly 27% of married female adolescents have reported an unmet need for contraception (MoHFW, 2006). According to the Census 2011, the population of the youth increased from 168 million to 422 million in 2011. However the sex ratio of the youth has worsened, from 961 in 1971 to 939 in 2011 and projected to drop to 904 in 2021. Over 2 in 5 (42.6%) of the economically active youth are unemployed in the world or are working yet living in poverty.

In India, data on adolescents from national surveys including National Family Health Survey III (NFHS-3), District Level Household and Facility Survey III and Sample Registration System call for focused attention with respect to health and social development for this age group. It has therefore been realized that, investing in adolescent health will yield demographic and economic dividends for India. In view of this, Government of India launched its first comprehensive programme for adolescents, 'Rashtriya Kishor Swasthya Karyakram', during January 2014 which has a sharp focus on adolescents' sexual health. The programme envisages that all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being. The RKSK tries to enable all adolescents realise their full potential and make informed and responsible decisions concerning their health and quality of life and be accessing the services and support they need to implement their decisions.

Evolution of Adolescent Health Policy in India

Planning for adolescents first began in the Tenth Five Year Plan (2002-2007). After this a Working Group on Youth Affairs and Adolescents Developments was formed in the Eleventh Five Year Plan (2007-2012). This group noted a few suggestions which included the setting up of counselling centres for adolescents and substance abusers and putting a special focus on minorities and out of school adolescents. The Draft Twelfth Plan also mentions the significance of the *SABLA* programme in the lines of the *Bal Bandhu Pilot Programme* for the protection of child rights.

As a signatory to the ICPD declaration, the Government of India initiated the development of an ARSH policy. While the RCH-I (Reproductive and Child Health)

Program (1998-2004) did not make any direct mention of adolescent health needs in the objectives or beneficiaries, NACP II (National AIDS Control Program II, 1999-2006) took the challenge seriously and introduced the School AIDS Education Programme (SAEP) in the 9th and 11th grades on a voluntary basis throughout India. Less explicit mention of adolescents was also because RCH-I was mainly concerned with structures and institutional capacities that would be utilized in RCH-II (2005-2010), where a specific focus on adolescent health was planned (UN 2008).

Adolescent Health Problems

The common health issues faced by the adolescents are sexual and reproductive (SRH), malnutrition, psychiatric, substance abuse and accidents. Sexual and reproductive ill health is the major cause of mortality and morbidity in adolescents. About 16 to 19% of the total pregnancies are teenage pregnancies. The risk of maternal death is about three times higher in girls aged 15–19 years and five times higher in those younger than 15 years compared to women in their 20s ,which is mainly due to unsafe abortion and post-partum hemorrhage. Unmet needs for family planning especially for spacing are high among adolescents at 24.7% in 2006.

Mental health problems are also on the rise among adolescents. The world mental health survey found that many mental health disorders usually start during childhood or adolescence, although diagnosis and treatment may be delayed for years. The prevalence of psychiatric morbidity among adolescents is in the range of 12 to 20% as reported in many studies in India. The pattern of symptoms include depression, conduct disorder, social anxiety and panic disorder. In India suicide is also high among adolescents than any other age group. Both mental and physical stress has been attributed to the rise in psychological problems .The prevalence of stress among adolescents is reported in the range of 16 to 25%.

Tobacco, alcohol and substance abuse are current serious issues concerned with adolescents as they are ignorant about its long term effects. The global youth tobacco survey across India reported an increase in the use of any form of tobacco from 13.7 to 14.6% and cigarette users from 3.8 to 4.4% between 2006 to 2009 among adolescents. A national level study found that 11% males and 1% females consumed alcohol with more consumption pattern in the urban areas than rural areas10. In a study among 9th to 12th grade students it was reported that 31.3% regularly use one or more substance. Evidence provided by SRS 1999, Census 2001, NFHS-II and DLHS-RCH 2004 particularly on early marriage, teen pregnancy, anemia and unmet need for contraception led Govt. of India to recognize the importance of adolescent health. In India, more than 50% of the illiterate girls get married before they reach the legal age of 18 years (ibid). Nearly 27% of married female adolescents have reported an unmet need for contraception (MoHFW, 2006).

Adolescent Health Care in India

There are many healthcare programmes under various ministries to address the problems of adolescents. However Government of India launched its first comprehensive programme for adolescents, 'Rashtriya Kishor Swasthya Karyakram', during January 2014 which has a sharp focus on adolescents' sexual health. The programme envisages that all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being. The RKSK tries to enable all adolescents realise their full potential and make informed and responsible decisions concerning their health and quality of life and be accessing the services and support they need to implement their decisions. .Other general adolescent involved programmes like the Nehru Yuva Kendra Sangathan (NYKS), National Service Scheme (NSS), Sarva Shiksha Abhiyan (SSA), and Integrated program for street children are also important resource for the well-being of this group. The Ministry of Youth Affairs and sports has developed a facilitator's manual on adolescent health and development in the year 2006 and have undertaken training of teachers and distributed learning resource material in the form of 12 modules to various NSS units, NYKS, and parent community.

Challenges and Issues concerning adolescent health care

As the Government's commitment to address the adolescent health needs by offering various programmes is acclaimed, there exist a gap between the service availability and the effective utilization of such services by the target group. Socio-cultural factors pose a major challenge in bringing the adolescents under the purview of health care. In a conservative society where reproductive and sexual health related issues are taboo for discussion, young people are hindered from actively seeking counselling for their needs .Early marriage of girls in practice is still a scourge in India. Married adolescent girls have little decision making power in the family, are socially isolated and so less likely to access the services. Data on adolescents from national surveys including NFHS-3, DLHS-3 and SRS has revealed that only 14% of married girls in the 15-19 age group have received complete antenatal care. In general these young people tend not to use existing reproductive health care services because of their belief that these services are not intended for them, concern that the staff will be hostile or judgmental, fear of medical procedures and contraceptives, lack of privacy, confidentiality, fear that their parents might learn of their visits, and shame, especially if the visit follows oppression or abuse. Though school based programmes have a better impact, many boys and girls of economically weaker sections of the society and those from rural areas are school dropouts. Knowledge and awareness regarding sexual and reproductive health among adolescents is still below average and most of them felt that their problems doesn't require visit to a health facility or just took home remedies.

As far as programme implementation is concerned, adolescent services operate under various ministries and some of the components of service overlap between them which may cause confusion and impede the effective utilization of men, material and money. The Ministry of Youth Affairs has been designated as nodal ministry for adolescent related interventions, but it is not a member in the mission steering group and the empowered committee under the National Health Mission (NHM), which may lack the power for its nodal role. ARSH has been an important inter-sectoral development under NHM. In case of inter-sectoral collaboration there should clarity on the role and limitations of each sector on what they can do. In a survey conducted to ascertain the views of health care providers in three Indian states it was found that the care givers were receiving, little training, if any, in non-judgmental communication methods with young people on sensitive topics, especially with opposite-sex adolescents, increasing provider discomfort with this topics. In a study conducted by the International Institute for Population Sciences and Population Council it was reported that just seven percent of young men and three percent of young women reported ever receiving information on sexual matters from a health care provider. As there is no separate manpower for adolescent health programmes, it is usually an extra burden on healthcare providers to handle sensitive issues of adolescent health, as it requires adequate time to gather information from clients.

The qualitative perspectives of the RH facilities, Adolescent Health Services (AHS), and Adolescent Friendly Health Services (AFHS) are still unexplored among the Indian adolescents. It is essential to furnish the adolescents with proper information as they can easily be misled and engage in unhealthy activities without such trainings. According to the literature, it is during this period that the adolescents are at the high risk of getting misled and having risky behaviour like substance abuse, unprotected sex, unintended pregnancy, and other RH issues. In India, the RH among the adolescents is an under investigated issue.

Rationale of the study

The number of adolescents (age 10-19 years) is increasing and comprises over one-fifth of the population in our country. They are not only in large numbers but are the future citizens and drivers of economic growth as the productive workers of tomorrow. Adolescents are not homogenous populations but exist in a variety of circumstances. A large number of them are out of school, get married early, work in vulnerable situations, are likely to be sexually active, and are exposed to several health risks. These have serious social, economic and public health implications for the nation. Their needs vary by their age, sex, stage of development, life circumstances, socio-economic status, marital status, class, region and cultural context. This calls for interventions that are flexible and responsive to their desperate needs. As the Indian Council for Medical Research (ICMR) acknowledges, despite 35 percent of the population being in the 10-24

age groups, the health needs of adolescents have neither been researched nor addressed adequately.

Objectives

1. To study the evolution of health policy in India for the adolescents.
2. To analyze the status of adolescent health in India.
3. To know the health services delivery processes for adolescents in Anwesha Clinics.
4. To understand the health service delivery outcomes of Anwesha Clinics in Birbhum.
5. To assess the enabling conditions for health services delivery in Anwesha Clinics with a focus on the Strengths Perspective in Social Work.

Research Setting

The study will be on the Anwesha clinics in Birbhum because:
i. Birbhum is one of the socio-economically marginal districts of West Bengal with an unmet need of health services.
ii. Researcher's familiarity with the setting.
iii. There has been no study on Anwesha clinics in Birbhum so far.

Methodology

1. **Research Design** –Descriptive
(Descriptive Research - A systematic and accurate description of the facts and characteristics of a given area of interest, Dulock, 1993; p 154)

2. **Approach to Methodology** – Mixed Methods (Eclectic research) involving Quantitative and Qualitative aspects in data collection and analysis.

3. **Social Work Practice perspective** – Strengths perspective focusing on the inherent abilities, advantages and resources of the existing health service delivery system to suggest means and measures of improvement (Kim, 2013).

4. **Analytical Framework** – Health Services Delivery Framework (WHO, 2015)

Figure 1.1 Health services delivery causal chain: health services delivery outcomes

Impact	Health system outcomes	HSD outcomes	HSD Processes*	Inputs*
Health impact (level and distribution)	Quality Accessibility Efficiency	Comprehensiveness Coordination Effectiveness Person-centredness	Selecting services Designing care Organizing providers Managing services Improving performance	Governing Financing Resourcing

From Health Services Delivery: A concept note (WHO 2015; p6)
www.euro.who.int/__data/.../Health-Services-Delivery-A-concept-note-301015.pdf

5. **Sample**

5.1 The research will be based on a survey of all the 22 functioning Anwesha clinics in Birbhum.

Block Primary Health Centres (BPHCs) – 15
Rural Hospitals (RHs) – 4 (Dubrajpur, Murarai, Sainthia and Labpur)
PM Hospital in Visva-Bharati – 1
District/Sub-divisional Hospital – 2 (Sian and Suri)
Total - 22

5.2 The study will include all the male (18) and female (19) counselors in the Anwesha Clinics (approximately 37 in number). The sample of respondents will also include the Block Medical Officers of Health (BMOH) of all the BPHCs, Medical Officers (MO) of RHs, the Chief Medical Officer of Health (CMOH) and the Director of Health Services of West Bengal.

5.3 A purposive sample of ten adolescent clients from all the clinics, that is a sample of 220 adolescents (approximately 50% each of male and female clients), will be taken for the study. Case studies of select adolescents will be taken for an in-depth understanding of the health delivery system.

5.4 FGDs will be conducted with adolescents involved in outreach activities in select Anwesha clinics across three subdivisions of Birbhum to have a further understanding of the families, communities and the context in awareness, accessing and utilizing Anwesha services.

6. **Data Analysis** – Triangulation (Quantitative and Qualitative)

7. **Methodology Matrix**

Objectives	**Type/ Source of Data**	**Conceptualisation**	**Methods**	**Tools**
1.Evolution of health policy in India for the adolescents	Secondary	Post-indepedence Plan period	Review Of literature	NA
2.Status of adolescent health in India	Secondary	Post-indepedence Plan period	Review of literature	Trend Analysis

3.Health services delivery processes for adolescents in Anwesha clinics	Primary	-Selecting services -Types of services -Standardisation of services -Pathways of services -Health workforce/ providers -Delivery settings -Management of services	Interview with Health Administrators, Anwesha counselors and Adolescent-clients.	Semi-structured Interview schedules
4.Health service delivery outcomes	Primary	-Comprehensiveness -Coordination -Effectiveness -People-centredness	Interview with Anwesha Counsellors and Adolescent-clients.	Semi-structured Interview schedule, Case study guide.
5.Enabling health system conditions	Primary	-Governance -Financing -Resourcing -Families, Communities and the Context	Interview with Health Administrators, Anwesha counselors, Case study of Adolescent-clients. FGDs	Semi-structured Interview schedule, case study guide, Interview guide, FGD Guide

9. **Glossary**

1. Health Services Delivery Framework – It is an integrated, action-oriented health systems framework committed to accelerating health systems reforms by the World Bank (2015)
2. Adolescents – Boys and girls in the age group of 10 to 19 years (NHM, GoI).
3. Adolescent Friendly Health Clinics (AFHCs) – Clinics attached to BPHCs and other government health providing units only to cater to physical and counseling needs of the adolescents. It is included in the National Health Mission and has been promoted under the umbrella scheme of Rashtriya Kishor Swasthya Karyakram (RKSK).
4. Anwesha Clinics – The Adolescent Friendly Health Clinics (AFHCs) are known as Anwesha Clinics in West Bengal at the Block Primary Health Centres (BPHCs).
5. Comprehensiveness – Range of services
6. Coordination – The resultant of selection, organization, management and improvement of services.
7. Effectiveness – The extent to which the delivery of services matches the desired outcomes.

Tentative Chapter Plan

I) Introduction
II) Review of Literature
III) Methodology
IV) Evolution of Adolescent Health Policy in India
V) Status of Adolescent in India
VI) Health services delivery processes for adolescents in Anwesha clinics.
VII) Health service delivery outcomes for adolescents in Anwesha clinics.
VIII) Enabling health system conditions for service delivery in Anwesha clinics.
IX) Discussion and Conclusion

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